Supreme Court, U.S.
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No. Record No. 03-1698

IN THE SUPREME COURT OF THE UNITED STATES

LEON HARRELL,

Petitioner,

v.

C NA INSURANCE COMPANIES, CONTINENTAL CAUSALTY COMPANY, QUORUM HEALTH GROUP, INC. AND QHG OF SOUTH CAROLINA, INC. d/b/a CAROLNIA'S HOSPITAL SYSTEM GROUP LONG TERM DISABILITY PLAN

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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QUESTIONS PRESENTED

1. **Where an original decision to deny benefits is an abuse of discretion, as a matter of law, should a plan administrator's upholding of the unjustified decision be considered an abuse of discretion as well?**

2. **Should a discovery request by a plan participant's attorney considered a written request for plan documents, for the purposes of 29 U.S.C. (s) 1132 (c)?**

3. **Under an evaluation of whether to award attorney's fees, should a Plaintiff be considered to have succeeded on the merits if the Court has imposed liability and awarded damages on one of the Plaintiff's causes of action?**

4. **Is the issue of whether discovery requests can trigger liability under 29 U.S.C. (s)1132(c) for a plan administrator which fails to produce a plan document with in 30 days of the request, a novel issue of law, which could be important to future Parties?**

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OPINIONS BELOW

The Court of Appeals wrote an unpublished Opinion in this case, affirming based on the reasoning in the District Court Judge's Orders filed on January 15, 2003, January 21, 2003, May 14, 2003, and May 15, 2003. A copy of the unpublished Opinion is included in the Appendix, as are the Orders of January 15, 2003, January 21, 2003, May 14, 2003, and May 15, 2003 from the District Court.

JURISDICTION

On February 2, 2004, the Appeals Court for the Fourth Circuit affirmed the District Court's denial of Mr. Harrell's Motion for Reconsideration. This Court Has Jurisdiction under 28 U.S.C. 1254(1).

CONSTITUTIONAL PROVISIONS AT ISSUE

None.

STATUTORY PROVISIONS AT ISSUE

The questions presented implicate the following provisions of the U.S. Code:
29 U.S.C.(s) 1132 (c)
29 U.S.C.(s) 1132(g)(1)
29 U.S.C.(s) 1024(b)(4)

Whether discovery requests from a plan participant's attorney satisfy the requirement of a "written request" under 29 U.S.C. sections (s) 1024(b)(4).

STATEMENT OF THE CASE

Prior to December of 1996, Leon Harrell, the Appellant, was a Cardiac Catheterization Lab Technician at Carolinas Hospital in Florence, S.C. He began to suffer from a degenerative disease called Sarcoidosis. Harrell applied for short term disability benefits, and then applied for long term disability benefits in 1996. Pam Ward was a disability specialist for the Appellees. Ms. Ward made a final decision to deny Harrell's benefits on May 15, 1998. In the denial letter, she stated, as the reason for the denial, that the record contained no specific limitations supporting total disability, and that the medical information presented failed to document evidence of a medical condition that would render Harrell disabled under the plan definition. However, the record did, in fact contain medical evidence

supporting a finding of disability, and no evidence to the contrary. After the trial of this case (it was tried by written brief), Judge Houck found that Ms. Ward's decision was arbitrary, and awarded the Plaintiff damages based on her bad faith denial of the claim. Harrell appealed Ward's arbitrary decision. As Judge Houck recognized, the denial from Ward hobbled his efforts to get further medical assessments, as the money for treatment had been discontinued. Harrell's doctor, Dr. Booth performed a medical exam on Mr. Harrell, and wrote a report, which Harrell submitted to the Board, stating that Harrell was disabled to the point that he could not perform his job, that his medications had been increased, and that, due to Sarcoidosis, Harrell was unable to perform any meaningful work. Harrell, who had recently been approved for Social Security Disability benefits, also gave the committee his vocational assessment records, and the finding of disability by the Social Security Administration. The Appeals committee denied Harrell's appeal, on the basis that Harrell had failed to submit further medical evidence. Though Judge Houck found that Ms. Ward's decision to deny Harrell's benefits was unjustified and an abuse of discretion, and, in fact imposed liability on the Appellees for that decision, he decided that the appeals committee's affirmation of that decision was not an abuse of discretion.

Harrell had also requested a monetary award based on the Appellees' failure to produce

a copy of the plan within 30 days of a written request for the plan by his attorney, via a discovery request. The Court denied this request, ruling that a discovery request from an attorney does not satisfy the statutory burden necessary for the award of damages.

Finally, Mr. Harrell requested attorney's fees and costs, which are potential awards under the ERISA statute. The Court denied his request, through an analysis which is discussed below.

REASONS FOR GRANTING THE WRIT OF CERTIORARI

THIS COURT SHOULD GRANT CERTIORARI TO DETERMINE WHETHER, IN ERISA CASES, THE AFFIRMATION BY AN ADMINISTRATOR, OF A LOWER DECISION BY AN ADMINISTRATOR, WHICH WAS AN ABUSE OF DISCRETION AS A MATTER OF LAW, MUST ALSO BE CONSIDERED AN ABUSE OF DISCRETION.

THE COURT SHOULD GRANT CERTIORARI TO DETERMINE WHETHER, IN ERISA CASES, A DISCIVERY REQEST FOR A COPY OF THE PLAN, FROM A PLAN PARTICIPANT'S ATTORNEY CONSTITUTES A WRITTEN REQUEST FOR THE PLAN, SUCH THAT A FAILURE TO PRODUCE THE PLAN WITHIN THE 30

DAYS PROSCRIBED BY 29 U.S.C. (s) 1132(C) WOULD TRIGGER AN AWARD OF PENALTIES.

THE COURT SHOULD GRANT CERTIORARI TO DETERMINE WHETHER, THE GRANTING OF JUDGMENT ON THE ISSUE OF LIABLITY IN AN ERISA CASE QUALIFIES AS A DETERMINATION THAT PLAINTIFF HAS SUCCEEDED ON THE MERITS FOR THE PURPOISES OF AN ATTORNEY'S FEE AWARD.

THE COURT SHOULD GRANT CERTIORARI TO DETERMINE WHETHER THE ISSUE OF WHETHER DISCOVERY REQUEST, REQUSETING THE PLAN DOCUMENTS, SENT TO THE PLAN ADMINISTRATOR BY THE PARTICIPANT'S ATTORNEY CONSTITUTE A WRITTEN REQUEST FO RTHE PLAN UNDER 29 U.S.C. (s)1132(c) IS A NOVEL ISSUE OF LAW, THE DETERMINATION OF WHICH COULD BE IMPORTANT TO FUTURE PARTIES.

I. **The Court should have considered the evidence in the record which shows that Pam Ward and the Appeals Board were employees of CNA Insurance Companies, creating a conflict of interest.**

The Court, in its Order of January 16, 2003, considers this case under an abuse of discretion standard, rather than the conflict of interest evaluation under Booth v. Wal Mart Stores, Inc., 201 F.3d 335 (4th Cir. 2000), noting that the Appellant did not argue conflict of interest in the Brief that was submitted in September of 2000. From the testimony and evidence before the Court, it is clear that a conflict of interest, as contemplated under the ruling from Booth v. Wal Mart Stores, Inc., 201 F.3d 335 (4th Cir. 2000), existed in this case.

The Decision in Booth v. Wal Mart Stores, Inc., 201 F.3d 335 (4th Cir. 2000) actually requires the Court to consider whether there is a conflict of interest or not as part of its inquiry into the case. The "conflict of interest" argument is not a separate cause of action. Under Booth v. Wal Mart, a standard was created for the Court to use in considering liability in ERISA cases. The Appellant argues, therefore, that the Court was under a duty to apply this standard, to affirmatively investigate, and include, in its consideration of this case, any evidence presented to it, which would show such a conflict of interest. In Ms. Ward's Deposition, produced as an exhibit to the Harrell's Brief filed in September of 2000, it is clear that she is being deposed as a 30(b)(6) witness for CNA Insurance, representing that company. (Rule 30(b)(6), F.R.C.P.) She also admits, on page 9 of her

deposition, that she was employed as a disability specialist with the Company when she made the decision to deny Mr. Harrell's application for benefits under the plan. The Court, in its Orders of January 16th and May 14th, found this decision to be an abuse of discretion.

The appeals board, which reviewed Ms. Ward's decision was also was part of CNA Insurance. There is no dispute over the fact that CNA is the same company that would have paid benefits to Harrell had Ms. Ward not abused her discretion and decided to terminate Mr. Harrell's benefits. This is proof of a conflict of interest, clear proof of the exact type of conflict of interest that the Booth Court contemplated when it required Courts to apply the less stringent conflict of interest test to decisions made under these circumstances. The U.S. District Court erred, as a matter of law, in failing to apply the less stringent standard to this case. Had the Judge applied the correct standard, the outcome of the case would most likely have been different. The appeals committee reviewing a decision which was unquestionably an abuse of discretion should have been found liable for adopting and continuing this abuse of discretion, especially where a conflict of interest existed, and the Appellees benefited financially and directly from the decision. Thus, this error of law was not harmless, and should form a proper basis for a reversal of the District Court's ruling.

II. The evidence upon which the Appeal Board relied in deciding that there was no objective medical evidence submitted concerning Harrell's disabled status does not meet the "substantial evidence" standard set forth in Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 232 (4th Cir. 1997).

In Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 232 (4th Cir. 1997), the Fourth Circuit set forth the controlling law concerning the standard for deciding whether an administrator's decision was "reasonable." For the decision to be considered reasonable, it must have two elements, 1) it must be the result of a deliberate, principled reasoning process, and 2) it must be supported by substantial evidence. The appeal board's decision was not based on a deliberate reasoning process, nor was it supported by substantial evidence.

The record shows that the Board did not apply a deliberate principled reasoning process to Harrell's appeal. Instead, it simply and unreasonably discounted and refused to accept Dr. Booth's medical examination of the Plaintiff and the report thereon as medical documentation, regardless of the fact that it was clearly a report equal to the type of report that its own physician would have been able to render under the plan's rules. The Plan allows the administrator's doctor to perform a "physical examination" of the applicant. It is only reasonable to believe that this

process would have some reason behind it, that the Board could consider the report and findings from such a "physical examination" as medical evidence sufficient to refute or support findings by the applicant's doctor. In any deliberate and principled reasoning process, the board would have at least deliberated on or subjected a doctor's report from a physical examination to some kind of reasonable consideration or scrutiny. Instead, it dismissed it out of hand.

Finally, there is no substantial evidence to support a finding that Harrell was not disabled. In fact there is no such evidence whatsoever. Where the administrator decides to go forward with a decision based only on one doctor's findings, it must accept the findings and conclusions of the one treating physician. The U.S. District Court found, citing Salley v. Dupont, 966 F.2d 1011 (5th Cir. 1992), that Ms. Ward was not entitled to ignore Dr. Booth's indication that Harrell was disabled. The Appeal Board, under the same rationale, may not simply ignore Dr. Booth's subsequent letter and report, especially when the report was based on an actual physical examination of Harrell, where there are no conflicting reports, and where the Defendant had chosen not to take advantage of its policies allowing their own doctor to do a parallel examination.

In cases where the Court did find substantial evidence to support the administrator's decision, the facts indicate that there were conflicting reports, and at least *some*

evidence directly supporting a "no-disability" finding. In Elliot v. Sara Lee Corporation, 190 F.3d 601 (4th Cir. 1999), the Court declined to apply the SSA "treating physician" rule to ERISA cases. That case, however, is clearly distinguishable from this one. The "treating physician rule requires the fact finder to give great deference to the testimony of a treating physician who has treated the patient over a long period of time, and requires an award of benefits where there is no contradictory evidence. In that case, the Court declined to consider applying this rule, not because it was an ERISA case, but because there were five other doctors on record, disagreeing with Elliot's physician. In Harrell's case, however, even if the treating physician rule is not applied, common sense leads to only one workable conclusion. If there is only one doctor, only one set of findings, and no contradictions (the only contradictory findings came from Ms. Ward, and that determination has already been determined, by the Court, to have been an abuse of discretion) how can there be a determination that the one set of medical findings I the record, based on direct physical examination, are wrong, without an abuse of discretion?

III. The Appeals Board's refusal to recognize Dr. Booth's report concerning a medical examination of Harrell on May 21, 1998 as "objective Medical evidence" upon which it could make a determination of disability renders other language in the plan meaningless.

In the Order of January 16, 2002, the Trial Judge based his decision that the appeal board had not engaged in an abuse of discretion on the finding that "Plaintiff, however, did not supply CNA with any medical evidence supporting his claim for continued disability, but instead attempted to gain reversal of CNA's denial of benefits by a phone call and a letter from Dr. Booth."(Order of 1-16-02, p. 9) The Judge, in reaching this decision, relied on Gooden v. Provident life & Accident Ins. Co., 250 F.3d 329, 335 (5th Cir. 2001), finding that Defendant is entitled to deny benefits where it requested medical records and the insured refused to provide them. In this case, however, the Gooden decision, from the fifth circuit, should not apply because Mr. Harrell did, in fact, provide medical documentation in support of his appeal, in the form of a medical examination and the report thereon from Dr. Both. (a letter of June 1, 1998) Dr. Booth had performed a medical examination of Mr. Harrell on May 21, 1998. The June 1, 1998 letter, from Dr. Booth, which the Court recognizes as having been before the Board at the time of its decision, is medical evidence. When a

licensed, Medical Doctor conducts a medical examination of a patient, physically, and gives a report on his findings and conclusions, such a report should be considered objective medical evidence. If a licensed physician's diagnosis and prognosis, given after a physical medical examination of a patient is not to be considered medical evidence, what is?

In Booth v. Wal-Mart, 201 F.3d 335 (4th Cir. 2000), the Court recognized a plethora of factors that must be considered in deciding whether an abuse of discretion occurred. One of the elements requires the Court to consider whether the administrator, in applying the plan to reach its denial decision, had applied the plan terms consistently. The standard is whether the challenged interpretation might render some language in the plain documents meaningless or internally inconsistent. Id. The Appellee's rejection of Dr. Booth's letter of June 1, 1998, reporting the findings, outcomes, and conclusions from a physical medical examination of Harrell as objective medical evidence upon which the appeals board could make a decision would be directly at odds with the provision of the plan applying the administrator's doctor to perform a "physical examination." If one doctor's report from a physical examination is meaningless, then, to be consistent, the board would have to reject any doctor's report based on physical examination as medical evidence. This would require the administrator to discount any report from its own physician as well (had it chosen to

use this policy), and render the provision allowing physical examination by its own doctor meaningless.

The Plan includes a section entitled "DEFINITIONS" which defines terms used in the plan documents. This section does not define "objective medical evidence" as opposed to "subjective" or "non-objective" medical evidence. The Fourth Circuit has decided that "When interpreting an ERISA health insurance plan, we utilize and apply ordinary principals of contract law, and we 'enforce the plan's plain language in its ordinary sense.'" Wheeler v. Dynamic Eng'g, Inc., 62 F.3d 634, 638 (4th Cir. 1995). When, however, a term use is ambiguous, that ambiguity is construed against the drafter of the plan, and it is construed in accordance with the reasonable expectations of the insured. Id." Bynum v. Cigna Healthcare, 287 F.3d 305 (4th Cir. 2002). In this case, the term "objective medical evidence," in light of other provisions in the plan, would include a written report from a medical doctor, reporting the findings, diagnosis, and prognosis of a patient based on a "physical examination." Specifically, the plan does allow for the administrator to have its own doctor perform a "physical examination" of the applicant as many times as the administrator wishes. It only stands to reason that this provision is included so that the administrator's doctor's report, after a physical examination (just like the one Dr. Booth performed) can be relied on as medical evidence from which the administrator can make a

decision. Therefore, the plan document, on its face must either recognize Dr. Booth's letter concerning a physical medical examination of Harrell on May 21, 1998 as acceptable objective medical evidence, or present a useless and meaningless provision, allowing an examination by its own doctors, but rendering it useless as a basis for consideration of a claim.

To find one such report acceptable as medical evidence, but the other unacceptable is irreconcilable, absent inconsistent application of the policies. The Court has already found that Dr. Booth's letter of June 1, 1998 was before the Board when it made its decision. As the letter was based on an examination which occurred after April 13, 1998 (the last date that the Appellees had received medical documentation before denial of Benefits), it is objective medical evidence of Harrell's disability, which was submitted ***after*** the decision to deny, and in support of the appeal. As the Harrell ***did*** present this evidence, it ***was*** an abuse of discretion to deny his appeal based on a finding that there was no objective evidence in the record to support a finding of disability.

IV. Plaintiff requests reconsideration of the Court's findings and decision concerning an award under 29 U.S.C. (s) 1132 (c)

A. Discovery requests should be considered a "written request under 29 U.S.C. (s) 1132 (c)."

There is little or no case law on the issue of whether discovery requests from a plan participant's attorney satisfy the requirement of a "written request" under 29 U.S.C. sections (s) 1024(b)(4). It does seem clear that the sole act of service of a Complaint upon the Administrator, commencing a lawsuit, may not suffice. This makes sense, as a Complaint requires an Answer, affirmation or denial of the allegations in the Complaint, and is not a request for information. Discovery requests, however, are much different. The Fourth Circuit has recognized that a written request from an attorney, on behalf of a plan participant, is considered a "written request" under the statute. Sedlack v. Braswell Services Group, Inc., 1234 F.3d 219 (4th Cir. 1998). The request for the plan description, in this case, came from Harrell's attorney. It was a discovery request. The first one, anyway, may have been dated three days after the close of discovery. However, on its face, it is a written request for a copy of the plan from a plan participant. In Sedlack, the Court correctly recognized that the statute is plainly written, and not open for much interpretation. All it requires is that the plan participant (which would include Harrell, under the Court's analysis in Sedlack) submit a written request for the materials. The Plaintiff's first set of discovery requests, submitted in May of 1999

should suffice, under the plain language of the statute. As the Judge noted in his Order, this issue may be a novel question for the Court. The Appellant respectfully submits that, possibly, the reason that there is no case law on the subject of whether discovery requests fulfill the definition of a written request under 29 U.S.C. (s) 1024(b)(4) is that the statute is so plainly written and that a request for production of documents so clearly meets the criteria of a "written request," that there ***should*** be no question as to whether the Plan Participant should prevail on the issue. The Court erred, as a matter of law, in determining that Harrell had not made a written request to the Appellees for a copy of the plan.

B. Delay in judicial proceedings without legal justification is recognized as prejudicial under the Federal Rules of Civil Procedure.

The Trial Judge found that Harrell was not prejudiced by Appellee's groundless refusal to produce the plan in this case. In the Sedlack case, the administrator claimed that it saw "privacy issues" in handing a plan over to an unknown attorney, though this excuse was rejected by the Court. Whereas, in this case, the Appellees have not asserted a justification for their refusal to produce a copy of the plan. Under the Federal Rules of Civil Procedure an unjustified motion, or action, taken for the purposes of delay is an offense that could warrant sanctions from the Court. Rule 11 of the Federal Rules of Civil

Procedure affirmatively prohibits an attorney from actions which are taken for the purpose of delaying a proceeding. The Courts are allowed to impose sanctions for discovery abuses, mainly because a delay in production of information, which hinders ongoing discovery, is considered to be, per se, prejudicial to a party's attempts to prosecute or defend a case. The statute, under which the Plaintiff is requesting an award (29 U.S.C. (s) 1024(b)(4) and 29 U.S.C. (s) 1132 (c)) grants damages, on its face, based solely on the timing of the administrator's response to a request in writing for the Plan documents. It does not mention that any further inquiry is necessary or even desirable. In this case, the Appellees have never offered any reason or justification at all for not producing the plan. In Sedlack, the administrator gave, as a justification, that it did not know if the attorney requesting the documents on Sedlack's behalf was actually representing him. The Defendant, in that case claimed that it was justified in refusing to respond to the attorney's written request as a measure taken to protect the privacy of the plan participants. This justification was rejected by the Court, as was the Defendant's assertion that it had denied the request "only once." The Court correctly noted that "This argument must fail as nothing in the statute requires that more than one request be made before penalties may be imposed. See 29 U.S.C. (s) 1132(c)." Id. The Appellees' delay in producing the plan is prejudicial, especially considering the fact that

litigation was ongoing during the pendency of the request. The simple fact that the discovery period was over by three days at the date of the first written request does not change the fact that the written request was made, nor does it excuse the Appellees from the duty to respond under the statute.

C. Refusal to produce the Plan during discovery is proof of bad faith

In Sedlack, the Court specifically took into consideration the fact that the Defendant refused to produce the Plan in response to the Plaintiff's requests for production. In this case, the Plaintiff made three requests. The first was on May 4, 1999, the second (though admittedly three days beyond the end of the discovery period), on October 4, 1999, and the third on April 10, 2000 (within the discovery period of a new scheduling Order.) The Defendant did not produce the Plan documents until May 9 2000 (the transmittal letter was dated 5-9-00). Refusing to produce the Plan in response to the Plaintiff's first requests for production, and then only producing it after being sued for damages for the lack of production should be considered as prejudicial and evidence of bad faith on the part of the Appellees.

D. A showing of prejudice is not a requirement for the imposition of sanctions under Sedlack.

In Sedlack v. Braswell, the Fourth Circuit, citing to an earlier case in which the issue was addressed, confirms that a finding of prejudice is not essential to form the basis of the imposition

of the penalty under 29 U.S.C. (s) 1132(c). "Although prejudice is a pertinent factor, 'it is not a prerequisite to imposing a penalty.' Davis v. Featherstone, 97 F.3d 734, 737-38 (4th Cir. 1996)." Sedlack v. Braswell Services Group, Inc. 134 F.3d 219 (4th Cir. 1998). Even if the Court were correct in finding that there was no prejudice to the Appellant, from the Appellee's refusal to produce the plan this should not have been fatal to a request for damages under the statute.

E. That Harrell could have obtained the plan through other means does not excuse the Defendant from having to comply with the statutory mandate.

The Trial Judge gave, as one reason for denying Appellant's request for an award under 29 U.S.C.(s) 1132(c), that the Plaintiff had other means of obtaining the plan description as the case had been filed and discovery was proceeding. In fact, however, at the time the first written request was made, the discovery period had lapsed by three days. But for the fact that the parties had agreed to request an extension of the discovery period, the Plaintiff would ***not*** have had this opportunity. Furthermore, the Fourth Circuit has already rejected the argument that, because other means of access to the plan were available to the plan participant, the administrator is excused from its duties to produce a copy of the plan documents upon written request. In Sedlack v. Braswell Services Group, Inc. 134 F.3d 219 (4th Cir. 1998), the Defendant asserted

that "contrary to the district Court's conclusion that it did not provide a copy of the plan until February 29, 1996, the opportunity to copy the plan was made available to Sedlack no later than January 29, 1996." The Court made short work of this excuse, once again, referring to the clear language on the face of the statute "The applicable regulations, however, required Braswell to provide a copy of the Plan, not merely to make it available for copying. See 29 C.F.R. Section(s) 2520.104b-1 (b) (2)." Id. The Trial Judge erred in finding that the fact that the plan may have been available through "other means" bars imposition of the penalties called for in 29 U.S.C. (s) 1132(c).

V. The Trial Court should not have denied Harrell's request for attorney's fees and costs.

When considering a request for an award of attorney's fees under ERISA, the Court applies five factors. In this case, the U.S. District Court Judge should have found that, under the applicable five factor test, Mr. Harrell was entitled to recover attorney's fees under 29 U.S.C. (s) 1132(g) (1). The five factors are:

(1) The degree of opposing parties' culpability or bad faith;

(2) The ability of opposing parties to satisfy a fee award;

(3) Whether a fee award against the opposing parties would deter other persons acting under similar circumstances;

(4) Whether the parties requesting attorney's fees sought to benefit all Participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and

(5) The relative merits of the parties' positions.

Sedlack v. Braswell Services Group, Inc. 134 F.3d 219 (4th Cir. 1998) citing Quesinberry v. Life Ins. Co. of North America, 987 F.2d at 1029.

A. The degree of the parties' culpability or bad faith

The Trial Judge weighed this factor in favor of the Appellees. This is inconsistent with the fact that the trial judge clearly found the Appellees culpable. The Court granted the Appellant damages, finding that the decision to deny benefits was an abuse of discretion. The trial Judge also specifically recognized that Ms. Ward's abuse of discretion did, in fact, prejudice the Plaintiff from being able to seek further treatment or testing through which he could more effectively have fought his appeal. It should be a common sense conclusion that, but for the abuse of discretion in terminating Harrell's benefits, Harrell would not have even been in the position of appealing at all.

The first factor requires a determination of bad faith **OR** culpability. The Court, by giving a verdict in the Appellant's favor, certainly found that the Appellees are culpable.

As to bad faith, the finding of such an abuse of discretion, with the foreseeable

consequences (that Harrell would be in a position to have to appeal in the first place and in a position of not having access to medical treatment which could have affected his ability to effectively appeal) is evidence of bad faith. The appeals board's refusal to accept a report from Harrell's doctor based on a physical medical exam, where the Plan itself allows them to rely on their own doctor's report from a physical exam is also a clear indication of bad faith. Finally, the fact that the decision makers were also the ones responsible for paying out the benefits which had been denied indicates a level of bad faith. Booth v. Wal Mart Stores, Inc., 201 F.3d 335 (4th Cir. 2000)

The Trial Judge's finding that an abuse of discretion occurred in the decision to deny Harrell's benefits should also have not been ignored as an indication of a high degree of bad faith in this case. Abuse of discretion is not something that arises from a mistake, or misunderstanding. It refers to an intentional overstepping of ethical or moral boundaries, a knowing choice to take action that will result in harm to another person.

B. Ability of the opposing party to pay an attorney's fee award

The Trial Judge indicated that he declined to even consider this factor, claiming that there was nothing in the record to consider. Ignoring this factor is an error of law. There is evidence upon which the Court can base a decision on this

factor. The Court can certainly consider the actual amount of attorney's fees requested by the Plaintiff in determining whether a Defendant can pay them. Harrell requested a total of $6,900.00, an amount about equal to the amount of damages that the Trial Judge actually awarded in this case and probably less than damages including pre and post judgment interest that was awarded. The Appellees are in the Business of paying money. Clearly they have the capacity to pay out benefits in the amounts promised under the plan. If they did not, they could not operate. If the Defendant can afford to pay a monthly benefit of over $2,000.00 for years to plan beneficiaries, it can afford to pay attorney's fees equal to about three months worth of those benefits. This factor should have been weighed in favor of the Plaintiff.

C. Whether a fee award will act as a deterrent

The Court did properly weight this factor in favor of the Plaintiff.

D. The Plaintiff's claim does involve a novel question concerning ERISA law, and an important one, as the issue is not limited to the specific fact pattern in this case.

The Trial Judge acknowledged that the issue of whether discovery requests, requesting the plan, qualify as a "written request" for plan documents, for the purposes of 29 U.S.C. (s) 1024(b)(4) is a novel one. However, the Court

denies that it is an important issue. This is an erroneous decision. Any issue of law which has arisen once will arise again. If this is a novel question, and is one that may arise again, it should be considered an important one. It is important to address novel issues of law and resolve them one way or another, if, for no other reason, than to establish precedent on which others can rely. Precedent is the basis for most decisions by the Courts, but that precedent has to begin somewhere. The Trial Judge should have weighed this factor in Harrell's favor, and found that a novel question on an issue which is not restricted to one certain set of facts (this one would be applicable to any case in which such a written request for the plan through discovery is made) is an important one.

E. The Trial Judge erred in considering the Plaintiff to have been unsuccessful on the merits of the case.

The final factor requires the Court to consider the relative merits of the parties' positions. Though the Court clearly found that Harrell's allegations were proven, that the Appellees did abuse their discretion in denying his claim for benefits, the Court weighed this factor in favor of the Appellees. There is no escaping the fact that Harrell prevailed on the merits of the most important question in the case. But for the Appellees' abuse of discretion, Harrell would not even have had to face the burdens of the appeals board, or its own abuse of discretion and bad faith in refusing to accept his doctor's medical

evidence establishing his disability. This factor should have been weighed in Harrell's favor, as he ***did*** succeed on the merits of the case.

CONCLUSION

The affirmation of a decision which was an unjustified abuse of discretion should not escape the taint of the original wrongdoing. Review committees, and appellate systems are specifically designed to allow a second guess, a set of checks and balances to ferret out abuses, mistakes, or injustices in the system below the appellate level. The appellate committee in this case upheld an abuse of discretion with yet another abuse of discretion, by claiming that Harrell had not submitted medical evidence when he clearly did.

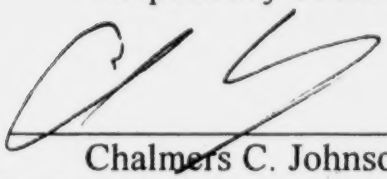
The Court should recognize a discovery request as a demand for documentation. That is the plain definition of a discovery request. To attempt to re-cast it as something other than a request from the represented party to the plan administrator simply denies the obvious nature of the action.

Finally, the specific facts and circumstances of this case to call for an award of attorney's fees and costs under ERISA. The Appellant respectfully requests that the Court issue an Order reversing the Trial Court's decisions on these three issues, and award Mr. Harrell damages for the loss of his benefits beyond the decision of the appellate committee, liquidated damages for the delay in producing the

plan, and attorney's fees and costs, as requested in the trial brief.

For the reasons set forth above, Petitioner LEON HARRELL respectfully prays that the Court grant a Writ of Certiorari to review the Judgment of the United States Court of Appeals for the Fourth Circuit in this case.

Respectfully Submitted,



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